

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00568

1. PLACE OF DEATH o. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jeanette Middle Lucille Last Ball		4. DATE OF DEATH Month Jan. Day 25 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1969
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR 3 Months 14 Days	IF UNDER 24 HRS. 14 Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Jessie Thompson		14. MOTHER'S MAIDEN NAME Josephine Ball	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Josephine Ball, La Plata, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. J. Edelen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. Edelen, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-25-'60	
22a. BYRIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1-25-60	22c. NAME OF CEMETERY OR CREMATORY St. Ignace	22d. LOCATION (City, town, or county) (State) La Plata Md
23. FUNERAL DIRECTOR'S SIGNATURE Richard E. LaPlata Md		24a. REC'D BY REGISTRAR DATE FEB 2 '60	24b. REGISTRAR'S SIGNATURE Arthur E. Kline

4000 294 XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> 0566 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN Td <u>X</u> <u>La Plata</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oak Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lily</u> First <u>BELL</u> Middle <u>BEVERLIN</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1945</u>
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR: Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Salem West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Burtis Beverlin</u>		14. MOTHER'S MAIDEN NAME <u>Margaret V. Puffenburger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Burtis Beverlin</u>		Address <u>Cumberland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fract. base of skull</u> <u>823x</u> DUE TO <u>Auto accident (occupant)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1-8-60</u> DUE TO (c) <u>1-8-60</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>front seat occupant, car left road</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-8-1960</u> Hour <u>9:45</u> a. m. <u>1-8</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>City Street La Plata Char. Md.</u>		20f. (City or town) (County) (State) <u>La Plata Char. Md.</u>	
21. Certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. Edehlen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-8-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 12 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pisgah, M.E.</u>		22d. LOCATION (City, town, or county) (State) <u>Pisgah, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS <u>Waldorf, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 13 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Charles

Marjorie

La Plata

Bellevue

May 1915

U.S.A.

Student
Bertha Berenson
Marjorie V. Berenson
Mrs. Bertha Berenson, Cambridge, Mass.

Marjorie Berenson
Bertha Berenson
Mrs. Bertha Berenson

0567 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>				c. LENGTH OF STAY IN 1b <u>1 day.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Newburg P.O.</u>			
3. NAME OF DECEASED (Type or print) First <u>WALLACE</u> Middle <u>EDWARD</u> Last <u>BOWLING</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 3, 1902</u>	
9. AGE (In years last birthday) <u>57</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Newport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Bowling</u>				14. MOTHER'S MAIDEN NAME <u>Nannie Higgs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>Mrs. Martha L. Bowling - Newburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion - 527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cs. Pulmonary</u> DUE TO (c) <u>Chronic emphysema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>7 years.</u> <u>9 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>63</u> , to <u>26 Jan</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>26 January</u> , 19 <u>60</u> , and that death occurred at <u>9:14 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur B. Woody</u>				ADDRESS (Street, city or town, state) <u>LA PLATA, MD.</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR B. WOODY</u>				DATE SIGNED <u>26 Jan 60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dentsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc. - La Plata, Md.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0568 CERTIFICATE OF DEATH

00566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville, Md. 18x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last BURROUGHS				4. DATE OF DEATH Month JANUARY Day 21 Year 1960			
5. SEX MALE		6. COLOR OR RACE W-05		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/21/60	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		13 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Kenneth Luther Burroughs				14. MOTHER'S MAIDEN NAME Martha Patricia Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Kenneth L. Burroughs, Mechanicsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY (6 1/2 mos. gestation) 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREMATURE RUPTURE OF MATERNAL MEMBRANES DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 15 MIN. 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/21 , 1960, to 1/21 , 1960, that I last saw the deceased alive on 1/21 , 1960, and that death occurred at 6:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hughesville, Md. DATE SIGNED 1/24/60							
ACTUAL SIGNATURE John H. Griffin M.D.				PHYSICIAN'S NAME (Type) John H. Griffin M.D. Hughesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/24/60		22c. NAME OF CEMETERY OR CREMATORY All Faith		22d. LOCATION (City, town, or county) (State) Charlotte Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR DATE JAN 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2166294XVI

0569 CERTIFICATE OF DEATH

00567

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH FRANK COOKSEY First Middle Last				4. DATE OF DEATH JAN 26 1960 Month Day Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1874		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Dealer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Cooksey				14. MOTHER'S MAIDEN NAME Mary Penn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frank Shymansky - Cobb Island, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 YEARS						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , to Jan 26, 1960 , that I last saw the deceased alive on JAN 25, 1960 , and that death occurred at 1:26 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) LA PLATA, Md. DATE SIGNED 1-26-60							
ACTUAL SIGNATURE F M Johnson M.D.				PHYSICIAN'S NAME (Type) FREDERICK M. JOHNSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/1960		22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Piney, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. ADDRESS La Plata, Md.				24a. REC'D BY REGISTRAR DATE FEB 2 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> 0570 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wayside</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Wayside</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>M</u> Last <u>FORD</u>				4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>4-1-1895</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland U.S.A.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacobus Ford</u>					
14. MOTHER'S MAIDEN NAME <u>Elyse</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Geckoy Ford</u> Address <u>1205 NE Washington Dr</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u> </u> (d) <u> </u> DUE TO <u> </u> (e) <u> </u> DUE TO <u> </u> (f) <u> </u> DUE TO <u> </u> (g) <u> </u> DUE TO <u> </u> (h) <u> </u> DUE TO <u> </u> (i) <u> </u> DUE TO <u> </u> (j) <u> </u> DUE TO <u> </u> (k) <u> </u> DUE TO <u> </u> (l) <u> </u> DUE TO <u> </u> (m) <u> </u> DUE TO <u> </u> (n) <u> </u> DUE TO <u> </u> (o) <u> </u> DUE TO <u> </u> (p) <u> </u> DUE TO <u> </u> (q) <u> </u> DUE TO <u> </u> (r) <u> </u> DUE TO <u> </u> (s) <u> </u> DUE TO <u> </u> (t) <u> </u> DUE TO <u> </u> (u) <u> </u> DUE TO <u> </u> (v) <u> </u> DUE TO <u> </u> (w) <u> </u> DUE TO <u> </u> (x) <u> </u> DUE TO <u> </u> (y) <u> </u> DUE TO <u> </u> (z) <u> </u> DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. Edeken</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-31-60</u>			
EXAMINER'S NAME (Type) <u>E. J. EDEKEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shilo M.E.</u>			
22d. LOCATION (City, town, or county) <u>Newburg</u>		(State) <u>MD</u>		24a. RECD BY REGISTRAR DATE <u>FEB 5 '60</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. LaPlante</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

0571

00569

Reg. Dist. No.....

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Charles		MARYLAND	STATE Md.		COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Waldorf		LENGTH OF STAY (in this place) life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Catherine L. Hagens			4. DATE OF DEATH (Month) (Day) (Year) Jan. 24 1960		
5. SEX F.	6. COLOR OR RACE C.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH May 14 1959		9. AGE last birthday yrs. 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Prince Georges County		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Hagens			14. MOTHER'S MAIDEN NAME Mary H. Heard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none	17. INFORMANT & ADDRESS William Hagens, Waldorf, Md.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION		
491X IMMEDIATE CAUSE (A) Acute Broncho Pneumonia (Bilateral)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
ANTECEDENT CAUSE(S) DUE TO (B) Virus Cold			48 hrs		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/27 , 19 59 , to 12/23 , 19 60 , that I last saw the deceased alive on 1/23/60 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.					
SIGNATURE V. M. Seron M.D.			ADDRESS (Street, city, town, state) Aquasco, Md.		
DATE SIGNED Jan. 25 1960					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-25-60		NAME OF CEMETERY OR CREMATORY St. Peters	
24. REC'D BY REGISTRAR DATE JAN 28 '60		REGISTRAR'S SIGNATURE Arthur S. Harris		25. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.	

2077328XV1

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. RACE White		5. BIRTH DATE May 15, 1892		6. PLACE OF BIRTH Baltimore, Md.	
7. OCCUPATION None		8. MARITAL STATUS Married		9. DATE OF DEATH Jan 25, 1960	
10. CAUSE OF DEATH Myocardial Infarction		11. ICD-9 CODE 410.91		12. PLACE OF DEATH Home	
13. SIGNATURE OF PHYSICIAN J. H. Harris		14. SIGNATURE OF WITNESSES J. H. Harris		15. SIGNATURE OF REGISTRAR J. H. Harris	
16. SIGNATURE OF DECEASED J. H. Harris		17. SIGNATURE OF NEXT OF KIN J. H. Harris		18. SIGNATURE OF BURIAL OFFICIAL J. H. Harris	
19. SIGNATURE OF CHURCH OFFICIAL J. H. Harris		20. SIGNATURE OF FUNERAL HOME J. H. Harris		21. SIGNATURE OF CEMETERY J. H. Harris	
22. SIGNATURE OF HEALTH DEPARTMENT J. H. Harris		23. SIGNATURE OF COUNTY CLERK J. H. Harris		24. SIGNATURE OF STATE CLERK J. H. Harris	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE COUNTY CLERK, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE STATE CLERK, BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00570

0572

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c. LENGTH OF STAY IN 1b 15-Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp. LaPlata Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James (Jne) Hedges		4. DATE OF DEATH 1-13-60	
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-20-1867
9. AGE (In years lost birthday) 92 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isiam Hedges		14. MOTHER'S MAIDEN NAME Miss Patterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank Catrufo Jr.		Address Indian Head Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Disease 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Artario Sclerosis DUE TO (c) Senility			
INTERVAL BETWEEN ONSET AND DEATH Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Patient fell at home and broke his left hip. This was nailed together			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell breaking left hip		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. 11-AM p. m. 12-30-59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Indian Head Md.	
21. I certify that I attended the deceased from 12-30-59 , 19____, to 1-13-60 , 19____, that I last saw the deceased alive on 1-13-60 , 19____, and that death occurred at 2-19-PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1-13-60			
ACTUAL SIGNATURE James E. Andrews		M.D. Indian Head Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/16/1960	22c. NAME OF CEMETERY OR CREMATORY Hedges Family Cemetery	22d. LOCATION (City, town, or county) (State) Hoaglev, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. LA PLATA, MD.		24a. REC'D BY REGISTRAR JAN 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

91-28101

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1990-1991 (continued)

2000

growth low up

— 200 —

doi:10.1017/S0007122612000027

Figure 1: A timeline showing the progression of the study from 2010 to 2012. The timeline includes key events such as the start of the study, data collection, analysis, and publication.

Wiley Periodicals

1940-1941, 1942-1943, 1944-1945, 1946-1947, 1948-1949, 1950-1951, 1952-1953, 1954-1955, 1956-1957, 1958-1959, 1960-1961, 1962-1963, 1964-1965, 1966-1967, 1968-1969, 1970-1971, 1972-1973, 1974-1975, 1976-1977, 1978-1979, 1980-1981, 1982-1983, 1984-1985, 1986-1987, 1988-1989, 1990-1991, 1992-1993, 1994-1995, 1996-1997, 1998-1999, 2000-2001, 2002-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011, 2012-2013, 2014-2015, 2016-2017, 2018-2019, 2020-2021, 2022-2023, 2024-2025, 2026-2027, 2028-2029, 2030-2031, 2032-2033, 2034-2035, 2036-2037, 2038-2039, 2040-2041, 2042-2043, 2044-2045, 2046-2047, 2048-2049, 2050-2051, 2052-2053, 2054-2055, 2056-2057, 2058-2059, 2060-2061, 2062-2063, 2064-2065, 2066-2067, 2068-2069, 2070-2071, 2072-2073, 2074-2075, 2076-2077, 2078-2079, 2080-2081, 2082-2083, 2084-2085, 2086-2087, 2088-2089, 2090-2091, 2092-2093, 2094-2095, 2096-2097, 2098-2099, 2100-2101, 2102-2103, 2104-2105, 2106-2107, 2108-2109, 2110-2111, 2112-2113, 2114-2115, 2116-2117, 2118-2119, 2120-2121, 2122-2123, 2124-2125, 2126-2127, 2128-2129, 2130-2131, 2132-2133, 2134-2135, 2136-2137, 2138-2139, 2140-2141, 2142-2143, 2144-2145, 2146-2147, 2148-2149, 2150-2151, 2152-2153, 2154-2155, 2156-2157, 2158-2159, 2160-2161, 2162-2163, 2164-2165, 2166-2167, 2168-2169, 2170-2171, 2172-2173, 2174-2175, 2176-2177, 2178-2179, 2180-2181, 2182-2183, 2184-2185, 2186-2187, 2188-2189, 2190-2191, 2192-2193, 2194-2195, 2196-2197, 2198-2199, 2200-2201, 2202-2203, 2204-2205, 2206-2207, 2208-2209, 2210-2211, 2212-2213, 2214-2215, 2216-2217, 2218-2219, 2220-2221, 2222-2223, 2224-2225, 2226-2227, 2228-2229, 2230-2231, 2232-2233, 2234-2235, 2236-2237, 2238-2239, 2240-2241, 2242-2243, 2244-2245, 2246-2247, 2248-2249, 2250-2251, 2252-2253, 2254-2255, 2256-2257, 2258-2259, 2260-2261, 2262-2263, 2264-2265, 2266-2267, 2268-2269, 2270-2271, 2272-2273, 2274-2275, 2276-2277, 2278-2279, 2280-2281, 2282-2283, 2284-2285, 2286-2287, 2288-2289, 2290-2291, 2292-2293, 2294-2295, 2296-2297, 2298-2299, 2300-2301, 2302-2303, 2304-2305, 2306-2307, 2308-2309, 2310-2311, 2312-2313, 2314-2315, 2316-2317, 2318-2319, 2320-2321, 2322-2323, 2324-2325, 2326-2327, 2328-2329, 2330-2331, 2332-2333, 2334-2335, 2336-2337, 2338-2339, 2340-2341, 2342-2343, 2344-2345, 2346-2347, 2348-2349, 2350-2351, 2352-2353, 2354-2355, 2356-2357, 2358-2359, 2360-2361, 2362-2363, 2364-2365, 2366-2367, 2368-2369, 2370-2371, 2372-2373, 2374-2375, 2376-2377, 2378-2379, 2380-2381, 2382-2383, 2384-2385, 2386-2387, 2388-2389, 2390-2391, 2392-2393, 2394-2395, 2396-2397, 2398-2399, 2400-2401, 2402-2403, 2404-2405, 2406-2407, 2408-2409, 2410-2411, 2412-2413, 2414-2415, 2416-2417, 2418-2419, 2420-2421, 2422-2423, 2424-2425, 2426-2427, 2428-2429, 2430-2431, 2432-2433, 2434-2435, 2436-2437, 2438-2439, 2440-2441, 2442-2443, 2444-2445, 2446-2447, 2448-2449, 2450-2451, 2452-2453, 2454-2455, 2456-2457, 2458-2459, 2460-2461, 2462-2463, 2464-2465, 2466-2467, 2468-2469, 2470-2471, 2472-2473, 2474-2475, 2476-2477, 2478-2479, 2480-2481, 2482-2483, 2484-2485, 2486-2487, 2488-2489, 2490-2491, 2492-2493, 2494-2495, 2496-2497, 2498-2499, 2500-2501, 2502-2503, 2504-2505, 2506-2507, 2508-2509, 2510-2511, 2512-2513, 2514-2515, 2516-2517, 2518-2519, 2520-2521, 2522-2523, 2524-2525, 2526-2527, 2528-2529, 2530-2531, 2532-2533, 2534-2535, 2536-2537, 2538-2539, 2540-2541, 2542-2543, 2544-2545, 2546-2547, 2548-2549, 2550-2551, 2552-2553, 2554-2555, 2556-2557, 2558-2559, 2560-2561, 2562-2563, 2564-2565, 2566-2567, 2568-2569, 2570-2571, 2572-2573, 2574-2575, 2576-2577, 2578-2579, 2580-2581, 2582-2583, 2584-2585, 2586-2587, 2588-2589, 2590-2591, 2592-2593, 2594-2595, 2596-2597, 2598-2599, 2600-2601, 2602-2603, 2604-2605, 2606-2607, 2608-2609, 2610-2611, 2612-2613, 2614-2615, 2616-2617, 2618-2619, 2620-2621, 2622-2623, 2624-2625, 2626-2627, 2628-2629, 2630-2631, 2632-2633, 2634-2635, 2636-2637, 2638-2639, 2640-2641, 2642-2643, 2644-2645, 2646-2647, 2648-2649, 2650-2651, 2652-2653, 2654-2655, 2656-2657, 2658-2659, 2660-2661, 2662-2663, 2664-2665, 2666-2667, 2668-2669, 2670-2671, 2672-2673, 2674-2675, 2676-2677, 2678-2679, 2680-2681, 2682-2683, 26

5210003

97-4-56-

1994

100

0573 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md				c. LENGTH OF STAY IN lb 8-Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial, LaPlata Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Oden Middle Hodges Last Hodges				4. DATE OF DEATH Month 1-24-60 Day 19 Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-6-1871	
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker				10b. KIND OF BUSINESS OR INDUSTRY Naval Powder Plant			
13. FATHER'S NAME Thomas Oden Hodges				14. MOTHER'S MAIDEN NAME Miss Craggett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas Oden Hodges Jr. (Son)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition DUE TO (c) Carcinoma of The Pancreas INTERVAL BETWEEN ONSET AND DEATH 12-Hours 4-Mths. Indefinite							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-23-60 , 19 19 , to 1-24-60 , 19 19 , that I last saw the deceased alive on 1-24-60 , and that death occurred at 8PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. Andrews				DATE SIGNED 1-25-60			
PHYSICIAN'S NAME (Type) James E. Andrews				M.D. Andrew			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		1-27-60		Burpy Oaks		Pennock Md	
23. FUNERAL DIRECTOR'S SIGNATURE Rehob Inc				ADDRESS LaPlata Md		24a. REC'D BY REGISTRAR DATE FEB 2 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00572

0574

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRYANTOWN				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRYANTOWN			
				f. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Ferdinand Middle Sinclair Last Johnson				4. DATE OF DEATH Month 1 Day 22 Year 1960			
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-11-39	
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min.		IF UNDER 24 HRS. Months 21 Days 21 Hours 21 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Restaurant			
11. BIRTHPLACE (State or foreign country) md				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Benedict Johnson				14. MOTHER'S MAIDEN NAME Irene ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 1956-1959 2-1734-1801			
17. INFORMANT Irene Johnson				Address Bryantown, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTERNAL HEMORRHAGE 981x DUE TO Bullet wound of chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO 1-23-60							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by Brother			
20c. TIME OF INJURY Month, Day, Year Hour 1:30 a.m. 1-23 1960 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. J. EDELEN				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. J. EDELEN				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 26, 1960				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY St. Mary's				22d. LOCATION (City, town, or county) (State) Bryantown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Finner				ADDRESS Waldorf Md			
24a. REC'D BY REGISTRAR JAN 28 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Finner			

Charles

7110

Bryantown

Charles
Bryantown

incisor

U.S.A.

MD

James Johnson, Bryantown, Md

James Johnson
Bryantown, Md

Superintendent

James Johnson, Bryantown, Md

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WALDORF-CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF	c. LENGTH OF STAY IN 1b 1 month	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MRS. THERESA R. JOHANSON		4. DATE OF DEATH Month JAN. Day 12 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 6, 1902
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) New York City, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MARTIN SCHELLER	
14. MOTHER'S MAIDEN NAME MARY MANDEL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Son - Rev. Richard Johanson - Waldorf Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Failure 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Coccyoma of Liver		INTERVAL BETWEEN ONSET AND DEATH 6-12 mos 1-2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 10, 1959 , to Jan 12, 1960 , that I last saw the deceased alive on Jan 9, 1960 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert M. Seron		DATE SIGNED 1/12/60	
PHYSICIAN'S NAME (Type) VAHEH M. SERON M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-14-60	22c. NAME OF CEMETERY OR CREMATORY GRACELAND CEMETERY	22d. LOCATION (City, town, or county) (State) RACINE WISCONSIN
23. FUNERAL DIRECTOR'S SIGNATURE Frank Gervais Sons, Inc., 1756 Pa. Ave. N.W.		24a. REC'D BY REGISTRAR DATE JAN 14 '60	24b. REGISTRAR'S SIGNATURE William S. Thoms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00574

1. PLACE OF DEATH a. COUNTY <u>IRONSIDES/ Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ironsides</u>		c. LENGTH OF STAY IN 1b <u>X</u> Ironsides (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theodore A. Keys</u>		4. DATE OF DEATH Month Day Year <u>1 16 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 5, 1932</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Nanjemoy, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Agustus A. Keys</u>		14. MOTHER'S MAIDEN NAME <u>Alice V. Keys</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes. (not known)</u>	
17. INFORMANT <u>Agustus A. Keys</u>		Address <u>-Nanjemoy, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured knee and base of neck</u> 823X DUE TO <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1-16-60</u> DUE TO (c) <u>1-16-60</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-16-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto which left the road - 1-16-60</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1-16-1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Poolesville Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/20/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ironsides, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Sine</u>		ADDRESS <u>APARTMENT FUNERAL HOME, INC. *LA PLATA, MD.</u>	
24a. REC'D BY REGISTRAR <u>JAN 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Sine</u>	

WASH. STATE DEPARTMENT OF HEALTH—BATHING 15

0577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY LOU McLAUGHLIN		4. DATE OF DEATH JAN 20 1960	
5. SEX Female		6. COLOR OR RACE W.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 19-1960	
9. AGE (In years last birthday) — yrs.		10. IF UNDER 1 YEAR 19 Months 45 Days — Hours — Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Joseph McLaughlin		14. MOTHER'S MAIDEN NAME Lala Blanche Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Wm. J. McLaughlin, Bel Alton, Md.		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6:30 PM JAN 19 , 19 60 , to 20 Jan , 19 60 , that I last saw the deceased alive on JAN 19 , 19 60 , and that death occurred at 1:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata Md. DATE SIGNED 1-20-60 ACTUAL SIGNATURE F. M. JOHNSON M.D. LA PLATA Md. PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/20/60	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph		22d. LOCATION (City, town, or county) (State) Morganza Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. McLaughlin ADDRESS La Plata Bel Alton Md.		24a. REC'D BY REGISTRAR JAN 25 '60 DATE —	
24b. REGISTRAR'S SIGNATURE William J. McLaughlin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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0578 CERTIFICATE OF DEATH

Reg. Dist. No. 00576

1. PLACE OF DEATH a. COUNTY <i>Charles County</i> Rt. 1 Box 145, Indian Head		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Indian Head</i>		c. LENGTH OF STAY IN 1b <i>8 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Indian Head</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>EDWARD</i> Middle <i>NEWMAN</i> Last <i>NEWMAN</i>				4. DATE OF DEATH Month <i>January</i> Day <i>26</i> Year <i>1960</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown</i> <i>3/15/83</i>	9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months <i>1</i> Days <i>26</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Minister</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clergy</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Frederick Newman</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Warren</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Margaret Warren</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Heart Disease</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Spontaneous</i>			
20c. TIME OF INJURY Month, Day, Year Hour <i>no injury</i> a.m. <i>19</i> m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
				20f. (City or town) (County) (State) <i>Arboretum, Charles Co., Md.</i>	
21. I certify that I attended the deceased from <i>10 Oct. 1959</i> to <i>26 Jan. 1960</i> , that I last saw the deceased alive on <i>25 Jan. 1960</i> , and that death occurred at <i>12:00 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>V.B. Dettor</i>		M.D. <i>La Plata, Md.</i>		DATE SIGNED <i>1-26-60</i>	
PHYSICIAN'S NAME (Type) <i>V.B. DETTOR, MD.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/1/1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	
				22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Ernest Jarvis Co., Inc.</i>			ADDRESS <i>1432 You St., N.W.</i>		24a. REC'D BY REGISTRAR <i>FEB 3 '60</i>
					24b. REGISTRAR'S SIGNATURE <i>Conrad S. Piana</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE OF DEATH

Page Two of Two

NAME OF DECEASED <i>John Doe</i>		MAY 1910	
DATE OF DEATH <i>May 1, 1910</i>		PLACE OF DEATH <i>Home</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		RELIGION <i>Methodist</i>	
MARRIED <i>Yes</i>		OCCUPATION <i>Teacher</i>	
EDUCATION <i>High School</i>		PREVIOUS ILLNESS <i>None</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
PLACE OF BIRTH <i>Maryland</i>		DATE OF BIRTH <i>May 1, 1865</i>	
PLACE OF DEATH <i>Home</i>		DATE OF DEATH <i>May 1, 1910</i>	
MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>	
PREVIOUS ILLNESS <i>None</i>		OCCUPATION <i>Teacher</i>	
EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>	
MARRIED <i>Yes</i>		RACE <i>White</i>	
AGE <i>45</i>		DATE OF DEATH <i>May 1, 1910</i>	
NAME OF DECEASED <i>John Doe</i>		MAY 1910	

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Ma b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Dr. Dettor's Office		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL T. RAY		4. DATE OF DEATH Month JAN Day 19 Year 1960	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4 1958
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ann Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Elizabeth Ford		Address Newburg, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Intraventricular Septum 754.2 DUE TO Intraventricular Septal Defect Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Known congenital PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Vomiting			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Congenital	
20c. TIME OF INJURY Hour (a.m. or p.m.) Month, Day, Year 11:10 a.m. 1-19-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) OFFICE		20f. (City or town) (County) (State) LA PLATA CHARLES MD	
21. I certify that I attended the deceased from 12-19-58 to 1-19-60 , that I last saw the deceased alive on 1-19-60 , and that death occurred at 11:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 1-19-60			
ACTUAL SIGNATURE J.B. Dettor M.D. La Plata, Md.			
PHYSICIAN'S NAME (Type) V. B. DETTOR MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-60	
22c. NAME OF CEMETERY OR CREMATORY Holy Ghost		22d. LOCATION (City, town, or county) (State) Irving, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		24a. REG'D. BY REGISTRAR Waldon	
24b. REGISTRAR'S SIGNATURE Carroll S. Thomas		DATE JAN 22 1960	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/SS

CERTIFICATE OF DEATH

Reg. Dist. No.

00578

0580

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head		c. LENGTH OF STAY IN 1b 7-Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		d. STREET ADDRESS 17-Potomac Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eugene Keith Roby		4. DATE OF DEATH Month Day Year 1-4-60 19		5. SEX Male		6. COLOR OR RACE W-US		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-11-1888		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Issiah Roby		14. MOTHER'S MAIDEN NAME Ida Estelle Cox		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Sister-Louise Roby Jones		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 287x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Obesity		INTERVAL BETWEEN ONSET AND DEATH 14-Hours Indefinite Indefinite		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1-5-60		(County)		(State)			
21. I certify that I attended the deceased from 1-1-52 , 19____, to 1-4-60 , 19____, that I last saw the deceased alive on 1-4-60 , 19____, and that death occurred at 11-P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1-5-60 DATE SIGNED James E. Andrews M.D. 17-Potomac Ave. Indian Head Md. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James E. Andrews													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-60		22c. NAME OF CEMETERY OR CREMATORY St Josephs		22d. LOCATION (City, town, or county) Pomfret Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE The Thrift Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE JAN 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knead							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN Frederick Snowden</u> First Middle Last 4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1960</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH (Unknown) <u>904</u> 9. AGE (In years last birthday) <u>56</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Ice Co.</u> 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> 12. CITIZEN OF WHAT COUNTRY? <u>?</u>			
13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Charles County Sheriff's Office - La Plata Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1-22-60</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>1-22-60</u> Hour <u>7</u> a. m. <u>PM</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> 20f. (City or town) <u>La Plata</u> (County) <u>Charles</u> (State) <u>MD</u>				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>E. T. EDELL</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-22-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 22b. DATE THEREOF <u>1-27-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Westport</u> 22d. LOCATION (City, town, or county) <u>La Plata</u> (State) <u>MD</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>La Plata Md</u> 24. REC'D BY REGISTRAR <u>FEB 2 '60</u> DATE 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

0582

CERTIFICATE OF DEATH

Reg. Dist. No.

00580

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland.</i> b. COUNTY <i>Charles.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Rock Point</i>		c. LENGTH OF STAY IN lb <i>Life time</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>THOMAS</i> First Middle Last <i>STINE</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>29</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 16, 1885</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Md</i>	
11. BIRTHPLACE (State or foreign country) <i>U S C</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S C</i>	
13. FATHER'S NAME <i>Jacob Stine</i>		14. MOTHER'S MAIDEN NAME <i>Lena Oily.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-12-7782</i>	
17. INFORMANT <i>Myrtle Stine Rock point Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident.</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>hypertensive Cardio vascular disease</i> (c) <i>Cir Pulmonalis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>40 min.</i> <i>5 years.</i> <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CHRONIC KIDNEY INFECTION</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>49</i> , to <i>29 Jan</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>29 January</i> , 19 <i>60</i> , and that death occurred at <i>11:25 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr Wooddy MD</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>30 Jan 60</i>	
PHYSICIAN'S NAME (Type) <i>ARTHUR O. WOODY</i>		<i>LAPLATA MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>2-1-60</i>	<i>Holy Ghost</i>	<i>Ilwaco Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Laplata</i>		24. REC'D BY REGISTRAR DATE <i>FEB 2 '60</i>	
25. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0584
CERTIFICATE OF DEATH

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Name", "Age", "Sex", "Race", "Occupation", "Cause of Death", "Date of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

[Faint, mostly illegible text at the bottom of the page, likely bleed-through from the reverse side. Some words like "Name", "Address", "City", "State", "County", "Date", and "Signature" are faintly visible.]

0583

CERTIFICATE OF DEATH

Reg. Dist. No.

00581

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle L. Last Thomas				4. DATE OF DEATH JANUARY 5 1960 Month JANUARY Day 5 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1887	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72		IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min. 72			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Nanjemoy, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Highfield				14. MOTHER'S MAIDEN NAME Atha Groves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. NONE.		INFORMANT Address Mrs. Florence Davis, Nanjemoy, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure DUE TO (b) Acute Myocardial Infarction DUE TO (c) Hypertensive Arteriosclerotic Heart Disease years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 36 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NAME OF MEDICAL EXAMINER) No accident							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Spontaneous							
20c. TIME OF INJURY Month, Day, Year Hour, a. m., p. m. 7:30 1-4 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Home		20f. (City or town) (County) (State) Nanjemoy, Charles, Md.	
21. I certify that I attended the deceased from 7-21 , 19 59 , to 1-5 , 19 60 , that I last saw the deceased alive on 1-5 , 19 60 , and that death occurred at 7:25 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE V.B. DETTOR				DATE SIGNED 1-5-60			
PHYSICIAN'S NAME (Type) V.B. DETTOR				ADDRESS (Street, city or town, state) Box 397 La Plata, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/1960		22c. NAME OF CEMETERY OR CREMATORY Nanjemoy Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Nanjemoy, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc., La Plata, Maryland				24a. REG'D BY REGISTRAR JAN 14 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1000

CERTIFICATE OF DEATH

0563

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00582

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benidect		c. LENGTH OF STAY IN 1b life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Chas. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benidect		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Benidect		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fredrick Arthur Thomas		4. DATE OF DEATH Month Jan. Day 7 Year 1960		5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 16 1893	
9. AGE (In years) 67		10. UNDER 1 YEAR Months 6 Days 6		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James E. Thomas		14. MOTHER'S MAIDEN NAME Ann Duckett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW1		17. INFORMANT Mrs. Josephine Pyndell, Washington, D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebro Vas. Accident DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1-7-60 ?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE E. J. Edelen		EXAMINER'S NAME (Type) E. J. Edelen MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/1960		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or county) Arlington, Va.		22e. LOCATION (City, town, or county) (State)		22f. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co., Inc.		23a. ADDRESS 1432 You St., N.W.		24a. REC'D BY REGISTRAR JAN 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hurd		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
DEPT. OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male		3. AGE 45	
4. OCCUPATION Engineer		5. PLACE OF BIRTH St. Louis, Mo.		6. DATE OF BIRTH Jan. 15, 1893	
7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF MEDICAL EXAMINER Wm. J. Smith		11. SIGNATURE OF WITNESSES J. J. Jones, J. K. Smith		12. SIGNATURE OF CLERK M. J. Brown	
13. DATE OF DEATH Jan. 20, 1930		14. TIME OF DEATH 10:30 A.M.		15. PLACE OF INTERMENT St. Mary's Cemetery	
16. NAME OF FUNERAL HOME John's Funeral Home		17. NAME OF UNDERTAKER John's Funeral Home		18. NAME OF CEMETERY St. Mary's Cemetery	
19. NAME OF CLERGYMAN Rev. J. J. Jones		20. NAME OF MINISTER Rev. J. J. Jones		21. NAME OF CHURCH St. Mary's Church	
22. NAME OF BURIAL PLACE St. Mary's Cemetery		23. NAME OF GRAVE St. Mary's Cemetery		24. NAME OF MONUMENT St. Mary's Cemetery	
25. NAME OF MONUMENT St. Mary's Cemetery		26. NAME OF MONUMENT St. Mary's Cemetery		27. NAME OF MONUMENT St. Mary's Cemetery	
28. NAME OF MONUMENT St. Mary's Cemetery		29. NAME OF MONUMENT St. Mary's Cemetery		30. NAME OF MONUMENT St. Mary's Cemetery	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00583

0588

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hayton P.O.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hayton P.O.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>E.</u> Last <u>TIBBS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1906</u>
9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>3</u> IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>23</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel Washington</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Sawoy</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <u>1253 Mt. Olive Rd NW, #3</u>	
17. INFORMANT <u>House</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>Hypertension & the disease</u> (b) <u>1950</u> DUE TO <u>1950</u> (c) <u>1950</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Under care of physician in D.C. and desire to have</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. E. DELEN</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. E. DELEN</u>		DATE SIGNED <u>1-23-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-27-60</u>		22b. DATE THEREOF <u>1-27-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		22d. LOCATION (City, town or county) (State) <u>Charles County, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHNSON-KENKINS WASH DC</u>		24a. REC'D BY REGISTRAR <u>JAN 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10196

1. PLACE OF DEATH e. COUNTY Charles MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sewage Plant, Potomac Heights				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last UNKNOWN		4. DATE OF FOUND DEATH Month Day Year January 27 1960		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Newborn			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Skull fracture with intracranial hemorrhage, with hemorrhage in soft tissues of neck DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Blow on head					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Unknown		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> <input type="checkbox"/> Found on dump		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Charles Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> W. Bradley King, Jr., M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/28/60 DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION JAN 29 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY MORRIS 22d. LOCATION (City, town, or country) (State) 700 FLEET ST.					
23. FUNERAL DIRECTOR R. S. FISHER, M.D. 9 VVVVVVVXVU		24a. REC'D BY REGISTRAR SEP 9 60 24b. REGISTRAR'S SIGNATURE Arthur J. Hesse					

MEDICAL CERTIFICATION

1944
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
NATIONAL CENTER OF HEALTH
VITAL STATISTICS
DEATH CERTIFICATE OF ORIGIN

NAME OF DECEASED
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SEX
AGE
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

1. Name of deceased
2. Date of birth
3. Place of birth
4. Date of death
5. Place of death
6. Cause of death
7. Manner of death
8. Sex
9. Age
10. Race
11. Religion
12. Education
13. Occupation
14. Marriage
15. Single
16. Married
17. Widowed
18. Divorced
19. Remarks

1944
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
NATIONAL CENTER OF HEALTH
VITAL STATISTICS
DEATH CERTIFICATE OF ORIGIN

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

M

X

1

2

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
058! MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00584									
1. PLACE OF DEATH e. COUNTY <u>Charles Co. md</u> <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaPlata</u>			c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaPlata</u>			d. STREET ADDRESS <u>La Plata md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES</u> <u>MELVIN</u> <u>WALLACE</u>					4. DATE OF DEATH Month Day Year <u>January</u> <u>17</u> <u>19 60</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 6, 1946</u>		9. AGE (In years last birthday) <u>13</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry H. Wallace</u>					14. MOTHER'S MAIDEN NAME <u>Margaret O. Johnson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If available give war or dates of service)		17. INFORMANT <u>Margaret Wallace</u> Address <u>La Plata md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent Meningitis.</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-18-60</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u> Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 13 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>La Plata md Charles Co md</u>			
23. FUNERAL DIRECTOR <u>George A. Nelson</u> ADDRESS <u>acquiares md</u>						24a. REC'D BY REGISTRAR DATE <u>JAN 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Cynthia S. Thomas</u>	

